07243

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

Reg. Diat. No. 281

1. PLACE OF DEATH:
County St. Mary's
City or town Pearson
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? —
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St. Mary's
City or town Pearson
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Agnes C. Barber

3. (b) Social Security Number —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife Francis
6.(c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) March 6, 1887

8. AGE: Years	Months	Days	If less than one day
58			hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation housewife
11. Industry or business

FATHER
12. Name Peter Compson
13. Birthplace Maryland

MOTHER
14. Maiden name Ann Taylor
15. Birthplace Maryland

16. Informant Agnes M. Barksdale
Address Pearson, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-7-45 (month) (day) (year)
Cemetery or crematory Holy Face
Location Great Mills
18. Funeral director W. B. Robinson
Address Leonardtown, Md.

19. 7-4-1945 (Date rec'd by registrar) J. J. Beamy M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 4 1945 at 6 40 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 3 1945 to July 4 1945 and that I last saw her alive on July 3 1945

Immediate cause of death	DURATION
Coronary Embolism	24 hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE J. J. Beamy M.D. M. D. or other
Address Great Mills, Md. Date signed 7-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
JUL 6 1945
BUREAU V. S.

07244

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (89)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 286

1. PLACE OF DEATH:

County St Marys

City or town Chaptico Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 44 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys

City or town Chaptico Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Lucy Barnes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	colored	married

6.(b) Name of husband or wife James F. Barnes

6.(c) If alive, give age 70 years

7. Birth date of deceased (mo., day, yr.) Dec 20 1879

8. AGE: Years	Months	Days	If less than one day
65	6	22	..... hrs. ..... min.

9. Birthplace Chaptico St Marys Md

(Town, county, and state)

10. Usual occupation Home wife

11. Industry or business

FATHER 12. Name Stephen Abard Young

13. Birthplace St Marys Co

MOTHER 14. Maiden name Hanna Thomas

15. Birthplace St Marys Co

16. Informant James F. Barnes

Address Chaptico Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 12 1945 (month) (day) (year)

Cemetery or crematory St Joseph

Location Mechanicsville Md

18. Funeral director W. C. Matthews Sons

Address Leonardtown Md

19. 7-11-1945 (Date rec'd by registrar) R. V. Palmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 11 1945, at 1.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-10-1945, to 7-11-1945

and that I last saw h. alive on 7-10-1945

Immediate cause of death	DURATION
Cerebral apoplexy	Unknown
Due to Hypertension	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. Palmer M. D. or other

Address Leonardtown Md Date signed 7-11-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 17 1963
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

07245

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: St Marys
City or town: Rural Leonardtown 2nd
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: St. Marys
City or town: Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Linda Teresa Bowman

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	Col	S

6.(b) Name of husband or wife —
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 16 1945

8. AGE: Years | Months: 4 | Days: 15 | If less than one day: hrs. min.

9. Birthplace: Rural Leonardtown Md (Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Thos Eugene Bowman
13. Birthplace: St Marys Co Md

MOTHER — 14. Maiden name: Lucy Robinson
15. Birthplace: St Marys Co Md

16. Informant: Lucy Robinson
Address: Leonardtown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14 45 (month) (day) (year)
Cemetery or crematory: St Aloysius Cemetery
Location: Near Leonardtown Md
18. Funeral director: Wm C Greenwell & Son
Address: Leonardtown Md

19. 7/1 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-1- 1945 at 7a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from death on 7-1 1945, to 1945 after
and that I last saw h alive on 19

Immediate cause of death	DURATION
Asphyxiation	
Due to: Heart and circulatory failure, probably	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F J Greenwell Coroner
M. D. or other
Address: Leonardtown Md Date signed 7-1-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A46

RECEIVED
JUL 5 1945
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07246

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: St. Mary's
City or town: Leonardtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 16 years
Hospital, Institution, or street address where death occurred:
How long in hospital or institution? 16 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St Mary's
City or town: Leonardtown Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. F. D. # 1
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Thomas Foley Drury Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	—

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 10- 1938

8. AGE: Years	Months	Days	If less than one day
7	1	22	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Student
11. Industry or business: —

FATHER
12. Name: Thomas Foley Drury
13. Birthplace: St. Mary's Co, Maryland

MOTHER
14. Maiden name: Florence Smale
15. Birthplace: Balto- Maryland.

16. Informant: Foley Drury
Address: Leonardtown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 5 1945 (month) (day) (year)
Cemetery or crematory: Our Lady chapel Leonardtown Md
Location: W Co Mattingly Lane
18. Funeral director: Leonardtown Md
Address:

19. 7/4 19 45 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1945, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 2 1945, to July 3 1945 and that I last saw h in alive on July 3 1945

Immediate cause of death	DURATION
Cerebral embolism	7/3/45
Due to: T + A Operation	7/2/45
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Chronic tonsils + adenoids
Date of op. 7/2/45
Autopsy results: none done
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Alexius C. Welch M.D.
M. D. or other
Address: Chaptico Md Date signed 7/3/45

RECEIVED
JUL 6 1945
BUREAU V.S.

84

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH ★

07247

Reg. Dist. No. 282

1. PLACE OF DEATH:
County: St Marys
City or town: Loveville Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: St Marys
City or town: Loveville Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: William J Hill

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Mary A. Hill
6.(c) If alive, give age: 67 years

7. Birth date of deceased (mo., day, yr.): 1861

8. AGE:

Years	Months	Days	If less than one day
84			hrs. min.

9. Birthplace: Loveville St Marys Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: —
FATHER 12. Name: Dr Hill
13. Birthplace: St Marys
MOTHER 14. Maiden name: Anna Hill
15. Birthplace: St Marys
18. Informant: Mrs Mary A Hill
Address: Loveville Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 17 1945 (month) (day) (year)
Cemetery or crematory: St Joseph Cemetery
Location: Morganza Md
18. Funeral director: W C McKinsie & Son
Address: Leonardtown Md
19. 7/16 45 Cancalen
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15 1945, at 1630 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1941 19.. to July 15 1945 and that I last saw h— alive on July 6 1945

Immediate cause of death	DURATION
Chronic Nephritis	
Due to	
Due to	
Other conditions Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Paul A Cancalen M. D. or other
Address: Leonardtown Date signed: 7/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 18 1945
BUREAU V.S.

1781

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 16-a

CERTIFICATE OF DEATH

117248 ★ Reg. Diat. No. 281

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County St Mary's
City or town Carver Heights, Pearson Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) Newborn
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County St Mary's
City or town Pearson Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Baby Jackson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 25, 1945

8. AGE: Years | Months | Days | If less than one day: 2 hrs. min.

9. Birthplace Carver Heights, Pearson St Mary's Co Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Raymond Meredith
13. Birthplace Virginia

MOTHER 14. Maiden name Mary Elizabeth Jackson
15. Birthplace Baltimore Md.

16. Informant Mary Elizabeth Jackson
Address Carver Heights. Pearson Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-25-45 (month) (day) (year)
Cemetery or crematory Ebenezer
Location New Market Md
18. Funeral director Wm. Marshall
Address Charlotte Hall Md

19. 7-25-45 (Date rec'd by registrar) 1945 W. Bray M.D. Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1945, at 2:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~July 25, 1945~~, 1945, to 1945, and that I last saw h alive on 1945.

Immediate cause of death Atelectasis Atelectasis — DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Wm H Patrick M.D.
M. D. or other
Address Pearson Md Date signed 7-25-45

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JUL 30 1945
BUREAU V.S.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07249

Reg. Dist. No. 178

1. PLACE OF DEATH:

County: St Marys

City or town: Holly Wood Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: St Marys

City or town: Holly wood (If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural #1 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Florence Jones

3. (b) Social Security Number

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: H E Jones

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Feb 17 1867

8. AGE: Years: 78 Months: 4 Days: 16 If less than one day ... hrs. ... min.

9. Birthplace: Oakville St Marys Md (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business

FATHER 12. Name: Benj F Grave

13. Birthplace: St marys co

MOTHER 14. Maiden name: Jane Woodburn

15. Birthplace: St Marys

16. Informant: H E Jones

Address: Holly Wood Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 6 1945 (month) (day) (year)

Cemetery or crematory: Joy Chapel

Location: Holly wood Md

18. Funeral director: W C Mattingley Sons

Address: Leonardtown Md

19. 7-4 1945 (Date rec'd by registrar) Cawood Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 3 1945, at 2.05 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 16 1945 to July 3 1945

and that I last saw her alive on July 03 1945

Immediate cause of death: Fibrillation / Myocarditis Chron — DURATION: 2 yrs

Due to

Due to

Other conditions (Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: J J Greenwell M. D. or other

Address: Leonardtown Date signed 7-3-45

RECEIVED
JUL 6 1965
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

CERTIFICATE OF DEATH

07250

★ Reg. Diat. No. 282

1. PLACE OF DEATH:

County St Marys

City or town Ridge Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 Month

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County St Marys

City or town Ridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary Diana Knott

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Divorced

6.(b) Name of husband or wife William Knott

8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 14 1871

8. AGE: Years	Months	Days	If less than one day
73	10	7	hrs. min.

9. Birthplace Near Leonardtown St Marys Md
(Town, county, and state)

10. Usual occupation House work

11. Industry or business

FATHER 12. Name Joe Goddard

13. Birthplace St Marys Co

MOTHER 14. Maiden name

15. Birthplace

16. Informant Mrs Louise Sumpkins

Address Ridge Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 24 1945 (month) (day) (year)

Cemetery or crematory St Michaels

Location Ridge St Marys Co. Md.

18. Funeral director W C Mathis Sons

Address Leonardtown Md

19. 7/23 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 21 1945 at 3.50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 9 1945 to July 21 1945 and that I last saw h.. alive on July 19 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to Hypertension	
Due to Chronic Nephritis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

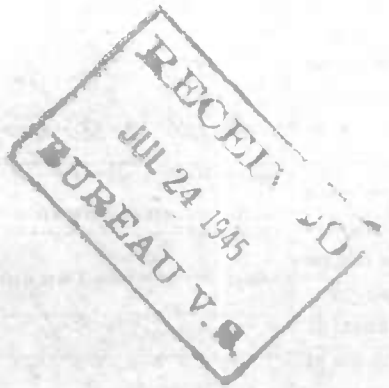
23. SIGNATURE Wm H Patuxent M.D.
M. D. or other

Address Pearson Md Date signed 7-22-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I MARGIN RESERVED FOR BINDING


RECEIVED
JUL 24 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

★ 07251

Reg. Diat. No. 282

1. PLACE OF DEATH:

County St. Marys

City or town Chesapeake Bay (Park Hall, Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St. Marys

City or town Park Hall (rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Leo Joseph Mireault

3.(b) Social Security Number 299-09-0613

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	unknown

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 9th 1896

8. AGE: Years	Months	Days	If less than one day
48			hrs. min.

8. Birthplace Saint-Alexis, Canada (Town, county, and state)

10. Usual occupation carpenter

11. Industry or business

FATHER 12. Name Octavien Mireault

FATHER 13. Birthplace Canada

MOTHER 14. Maiden name Domithilde Beaudoin

MOTHER 15. Birthplace Canada

16. Informant Aldanie Lefetiere

Address 3533 St.Catherine St.E.Montreal

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-6-45 (month) (day) (year)

Cemetery or crematory Ceder Hill

Location Washington, D.c.

18. Funeral director P. B. Robinson

Address Leonardtown, Md.

19. 8-6-45 (Date rec'd by registrar) Chevalier Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 29 th 19 45 (or) am M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from on 8-1 19 45, to 19

and that I last saw h alive on 19

Immediate cause of death	DURATION
Suffocation	
Due to Drowning Accidental	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of July 29-45

Where did injury occur Chesapeake Bay Park Hall Md (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F F Greenwell Coroner M. D. or other

Address Leonardtown, Md. Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 7 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137)

CERTIFICATE OF DEATH

17252

Reg. Dist. No. 2-4

1. PLACE OF DEATH:

County St. Mary's

City or town Rural Leonardtown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County St Mary's

City or town Rural Leonardtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harry Vincent Neale

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife Mary Caulin Neale

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) 6-25-1894

8. AGE: Years 51 | Months 1 | Days 1 | If less than one day ... hrs. ... min.

9. Birthplace Washington D.C. (Town, county, and state)

10. Usual occupation Veterinarian

11. Industry or business

FATHER 12. Name George Warren Neale

13. Birthplace Washington D.C.

MOTHER 14. Maiden name Columbia City

15. Birthplace Washington D.C.

16. Informant Columbia City

Address Bethesda Md R.R. 3 Box 232

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-31-45 (month) (day) (year)

Cemetery or crematory Glen Wood

Location Washington D.C.

18. Funeral director Martin W. Hyson Co

Address 1300 Conn Ave Washington D.C.

19. 7-29-45 (Date rec'd by registrar) R. V. Talen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-29-1945 at 1309 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on dead 7-29-1945

Immediate cause of death	DURATION
(a) Coronary occlusion	Instantaneous
Due to, or as a consequence of (b) Chronic nephritis	Years
Due to, or as a consequence of (c) Stomach ulcer	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Robert V. Talen M. D. or other

Address Leonardtown Date signed 7-29-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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AUG 3 1945
BUREAU V. S.

VS A15 (T)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

★ 7253 282 ~~280~~

Reg. Diat. No.

1. PLACE OF DEATH:

County St Mary's

City or town Saint Inigoes Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Mary's

City or town Saint Inigoes

(If outside city or town limits, write RURAL and give nearest town)

Street No. Mechanicsville R. F. D. # 1

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ollie Viola Powell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1 1871

8. AGE: Years 74 | Months 4 | Days 16 | If less than one day ... hrs. ... min.

9. Birthplace Miami Champaign Ohio (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name Jabez Vinyard

FATHER 13. Birthplace Champaign Co Ohio

MOTHER 14. Maiden name Jane Marty

MOTHER 15. Birthplace Ky Pa

16. Informant Mrs Maude A. Mademan

Address Mechanicsville Md R.F.D. #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 20 1945 (month) (day) (year)

Cemetery or ... Preston

Location Alger, Ohio

18. Funeral director W. C. Mattingley Sons

Address Leonardtown Md

19. 7/18 1945 (Date rec'd by registrar) Cawdley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 17 1945, at 2:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 16 1945, to July 17 1945, and that I last saw ... alive on June 16 1945

Immediate cause of death Chronic Myocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Jas. A. Cawdley M. D. or other

Address Leonardtown Date signed 7/18/45

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JUL 20 1945
BUREAU V.R.

P7254

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH ★

Reg. Dist. No. 881

1. PLACE OF DEATH:

County St Marys

City or town Rural St Inigoes

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County St Marys

City or town Rural St Inigoes

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Gloria May Shubrooks

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Black	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 11, 1945

8. AGE: Years — Months — Days 29 — If less than one day hrs. min.

9. Birthplace St Inigoes Md (Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name Robert Shubrooks

13. Birthplace Maryland

MOTHER 14. Maiden name Mary Bowles

15. Birthplace Maryland

16. Informant Mary Bowles

Address St Inigoes

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 11 1945 (month) (day) (year)

Cemetery or crematory Mt Zion Cemetery

Location St Inigoes, Md

16. Funeral director James Busch

Address St Inigoes, Md

19. July 10 1945 (Date rec'd by registrar) O J Bean MD Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1945 at 7A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 8 1945 to July 10 1945

and that I last saw h— alive on July 8 1945

Immediate cause of death	DURATION
Entero-colitis	2 weeks
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE O J Bean MD M. D. or other

Address Great Mills Md Date signed July 10/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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JUL 13 1945
BUREAU V.S.